Assessing Quality Adolescent Substance Use Services

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Performance Measurement

- Defining quality and tracking outcomes has become a focal point in determining the performance in healthcare (physical and behavioral).
- Private and public insurance funders, federal, state and local governments are implementing quality monitoring.
- Health plans, direct service organizations and agencies are attempting to become more accountable by using system/provider network performance and client outcomes as evidence of service efficiency and effectiveness.
- Health plans are moving toward performance-based (pay for performance) provider contracts.
- Need objective measures to implement performance measurement.

Measuring performance: Data trade-offs

- Many types of data:
  - Case records
  - Survey data
  - Management reports
  - Accreditation/regulatory requirements
  - Administrative data (billing/encounter data)
- Administrative data has common elements (UB-92, CMS 1500 etc) for commercial and Medicaid/SCHIP plans.
- This presentation addresses the advantages and challenges of using administrative data to assess the quality of behavioral healthcare services for youth.

Advantages of Administrative Data Measures

- Administrative data may be process of care focused.
- Versatility - Administrative data measures may be used at the system, group or individual provider levels.
- At the system level:
  - Ability to identify differential performance among service system components (e.g., preferred provider organizations (PPO) versus health maintenance organizations (HMO), integrated vs carve-out arrangements, etc.)
Advantages of Administrative Data Measures

- Measures may map how consumers move through the service system
- Measures have the potential to follow consumers through medical and behavioral health treatment as well as prescription drug use

Using Administrative Data: Challenges

Data accuracy
- Coding may be influenced by:
  - Diagnostic issues
    - Individuals with milder impairment may not be formally diagnosed with a DSM-IV or ICD-9/ICD-10 code
    - No SU experimentation codes
    - Individuals with mild/moderate impairment would not be expected to use services in the same way as individuals with serious emotional and behavioral impairment.
      - Diagnostic variability in mental health adds to the difficulty
  - Co-occurring disorders
    - Only one DX usually required
    - New codes may be needed for integrated treatment
  - Stigma
    - Providers may still be reluctant to use substance use disorder or serious mental health disorder codes for youth
  - Parity
    - Public policy may influence provider behavior
  - Service authorization
    - Influence of contract language
  - Reimbursement
    - Typically lower reimbursement rates for substance use (SU) influences the use of mental health (MH) coding in co-occurring MHSU disorders
    - Multiple diagnoses are not required and do not result in higher reimbursements rates
  - Difficult to obtain information across fragmented health care systems
    - Primary care
    - Specialty care
    - Pharmacy data
  - Linking across service systems
    - Youth receive treatment in a variety of settings
      - School clinics
      - Child welfare systems
      - Juvenile justice
The Bottom Line
- Need objective measures to implement performance measurement
- Need to follow process of care
- Must know and address data limitations
- Measures using administrative data can contribute to performance monitoring and quality improvement

Promising Initiatives
- Washington Circle
  - Measures for adult substance use disorder treatment
  - Apply to MH/SA treatment for children and adolescents
- Forum on Performance Measurement in Behavioral Healthcare and Related Service Systems
  - Adult mental health/substance use disorders
  - Child/adolescent mental health/substance use disorders
  - Substance use disorder prevention/mental health promotion
  - Methodology

Assessing The Process of Care
Adolescent Mental Health and/or Substance Abuse Disorders
Ann Doucette, Ph.D.
Vanderbilt University

Performance Measurement: What We Have and What We Need
- Accurate estimates of system level performance:
  - Identifying treatment opportunities (Identification)
  - Prompt treatment response (Initiation)
  - Sufficient exposure to treatment to render favorable outcomes (Engagement)
- Sensitive, real time estimates of meaningful clinical change over time
- Informative characterization of process indicators (therapeutic alliance, treatment modality, readiness to change, etc.)
- Meaningful feedback to consumers (youth and families), clinicians/providers, and system administrators

Why Assess The Process Of Care?
- Basic Premise
  - Important to identify individuals in need of treatment/intervention
  - Once identified, receiving services/intervention sooner than later is optimal
  - Timely intervention will
    - Interrupt adverse trajectories
    - Reduce the need for more intensive intervention or lengthen the need for more intensive intervention
    - Improve individual outcomes
    - Be less costly

Process of Care Continuum
- Prevention/Screening: awareness, assessing and reducing risk
- Education: self-management
- Recognition/Identification: case finding, assessment, referral for treatment
- Treatment: broad array of services (psychiatric/psychological, medical, counseling, social services, non-traditional and wraparound services, peer-support, etc.)
- Maintenance: services needed to sustain treatment effects and to reduce the needs for more intensive service episodes
  - Step-down care
Washington Circle

Process of Care Measures

- Conceptualized, Specified, and Piloted
  - Identification of substance use disorder
  - Initiation of substance abuse treatment
  - Engagement in substance abuse treatment
- Conceptualized
  - Screening
  - Maintenance of treatment effects
  - Family involvement in treatment

Defining the Client Population

- Diagnostic Groups
  - Substance Use Disorders
  - All serious emotional/mental health disorders
  - Co-occurring
- Age groups
- Gender
- Race/ethnicity
- Voluntary status

Process Of Care – Separating New and Continuing Clients

- New claim episode of care: specification allows for a service-free period prior to the identification claim so that the beginning of a new episode of services can be measured.
  - A 60-day period has been specified for adult substance abuse service systems
  - A 90-day period has been tested for adolescent substance abuse and mental health
    - The 90-day period captures most follow-up and medication monitoring check-ups
    - Other time intervals will be tested to determine which time interval is most relevant across behavioral healthcare service sectors

Defining the Data File: Inclusion – Exclusion Criteria

- 44 days needed to meet treatment engagement criteria
- 60/90 days needed to identify new treatment episode

Note: If data from previous years are available, service-free period can be estimated using prior calendar years.

Specification for Adolescents*

- **Identification:**
  - % of adolescents with a SA/MH diagnosis or use of an indicated service per 1000 health plan members (full and part time year)

- **Initiation:**
  - Adolescent members with SA admission or a SA outpatient index service and an additional SA or MH service within 14 days
  - Adolescent members with index SA claim

- **Engagement:**
  - Adolescent members with two or more SA or MH services within 30 days after initiation
  - Adolescent members with index SA claim

* Specification are different for adults treated for substance abuse. See [www.washingtoncircle.org](http://www.washingtoncircle.org)

Issues In Treatment: What’s Counted As Quality Care?

- Should mental health services count as indication of the quality of care for youth with substance use disorders?
  - Youth with co-occurring disorders have poorer outcomes when either the SUD or the mental health disorder(s) go untreated
  - Integrated interventions have been shown to increase engagement and retention in treatment for many youth
  - Many service researchers feel that integrated treatment of the co-occurring problems is essential
Adolescent Pilot Study: Identification

<table>
<thead>
<tr>
<th>Age</th>
<th>Mental Health Diagnosis</th>
<th>Co-Occurring Substance Abuse Mental Health</th>
<th>Substance Abuse Only Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth through 5 yrs (N=180,108)</td>
<td>.1%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>6 through 11 yrs (N=213,034)</td>
<td>5.0%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>12 through 15 yrs (N=157,895)</td>
<td>6.0%</td>
<td>.1%</td>
<td>.08%</td>
</tr>
<tr>
<td>16 through 18 yrs (N=127,037)</td>
<td>6.0%</td>
<td>.4%</td>
<td>.2%</td>
</tr>
</tbody>
</table>

Adolescent Pilot Study: Initiation and Engagement Rates

<table>
<thead>
<tr>
<th>Age</th>
<th>Initiation Mental Health Diagnosis</th>
<th>Engagement Mental Health Diagnosis</th>
<th>Co-Occurring Substance Abuse Mental Health Diagnosis</th>
<th>Co-Occurring Substance Abuse Mental Health Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 through 15 yrs (N=157,895)</td>
<td>30%</td>
<td>16%</td>
<td>55%</td>
<td>35%</td>
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<tr>
<td>16 through 18 yrs (N=127,037)</td>
<td>36%</td>
<td>20%</td>
<td>47%</td>
<td>27%</td>
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</tbody>
</table>

Next Steps: Additional Questions To Address
- Association between meeting the *Initiation* and *Engagement* criteria and
  - Treatment outcomes
  - Subsequent treatment episodes
    - Time interval between episodes of care
    - Impairment level of subsequent episodes
    - Empirically-supported treatment models
    - Integrated care models